GUADALUPE FAMILY HEALTH, PA

PATIENT PEDIATRIC HEALTH HISTORY FORM

Please fill out completely prior to your child's visit with us. For well-child checks, please also use the appropriate well-child questionnaire. Thank you.

CHILD'S NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

Child's previous doctor/PCP: _____

BIRTH AND PREGNANCY:

What city was your child born in? _____ Name of hospital: _____

Is this your child by: ☐ Birth ☐ Adoption ☐ Step-child ☐ Other: _____

Birth weight: _____ Was your baby premature? ☐ Yes ☐ No

Were there any significant medical problems during your pregnancy? ☐ Yes ☐ No

Were there any significant complications during labor or the baby's newborn period? ☐ Yes ☐ No

If yes, to any of the above questions, please explain: _____

GROWTH AND DEVELOPMENT:

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.)?

☐ Yes ☐ No If yes, please explain: _____

Girls only: Age at first period: _____

PAST MEDICAL HISTORY:

Has your child:

Had any serious medical illness?	☐ Yes	☐ No	Had broken bones/frequent or severe sprains?	☐ Yes	☐ No
Had a history of asthma or wheezing?	☐ Yes	☐ No	Had any mental or behavioral problems?	☐ Yes	☐ No
Ever used an inhaler or nebulizer?	☐ Yes	☐ No	Had a positive tuberculosis skin test?	☐ Yes	☐ No
Had surgery?	☐ Yes	☐ No	Been hospitalized overnight?	☐ Yes	☐ No

If yes, to any of the above questions, please explain: _____

IMMUNIZATIONS: *Please bring your child's immunization records to your appointment*

Have you ever refused vaccines for your child? ☐ Yes ☐ No

If yes, please explain: _____

MEDICATIONS AND ALLERGIES :

Please list current medications, vitamins, and supplements, even those used intermittently: _____

_____

Please list allergies or reactions to medications, vaccines or foods:

Allergy	Reaction

SOCIAL HISTORY:

Please list patient's family and household members:

Name	Age	Relationship	Occupation/Employer	Cell Phone Number

Are your child's parents:

☐ Married ☐ Unmarried ☐ Separated ☐ Divorced (if divorced or separated, when? _____)

Child-care situation:

☐ Parents ☐ Others (specify who and hours per day: _____)

Concerns about your child:

☐ Alcohol use ☐ Tobacco ☐ Sexual Activity ☐ Aggresive Behavior

Is violence at home a concern? ☐ Yes ☐ No Are there pets in the home? ☐ Yes ☐ No

Are there guns in the home? ☐ Yes ☐ No Do any family members smoke? ☐ Yes ☐ No

FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma												
Autism												
Autoimmune Disorder												
Birth Defect/Congenital Anomaly												
Bleeding Problem												
Cancer, Breast												
Cancer - Please specify type:												
Cancer - Please specify type:												
Depression												
Diabetes												
Eczema (Atopic Dermatitis)												
Food Allergy												
Genetic Disorder												
Hay Fever (Allergic Rhinitis)												
Hearing Disorder												
Heart Attack/Coronary Artery Disease												
High Cholesterol (Hyperlipidemia)												
High Blood Pressure (Hypertension)												
Immune Disorder												
Inflammatory Bowel Disease (Crohns/UC)												
Kidney Disease												
Mental Retardation or Learning Disability												
Migraine Headaches												
Psychiatric/Mental Illness												
Scoliosis												
Stroke												
Substance Abuse												
Thyroid Disorders												
Tobacco Use												
Tuberculosis												
Death Before Age 56 or Reasons Not Listed Above												
Other:												
Other:												